FOR OFFICE USE ONLY	Case # MMWR Date	Counted Y ☐ N ☐ → ☐ Trans-In ☐ Non TB ☐ Reactivation	Source Case #

UPDATE REPORT	TUBERCULOSIS CASE REPORT Washington State DOH STD/TB Services PO Box 47837 Olympia, WA 98504	Date Submitted ☐☐ Month ☐☐ Day ☐☐☐☐ Year Transfer-In? ☐ Yes ☐ No	Client ID # TIMS #

CLIENT INFORMATION

CLIENT NAME:

Last _____

First _____

Middle _____

Alias _____

CLIENT DOB: ☐☐ Month ☐☐ Day ☐☐☐☐ Year

SEX: ☐ Male ☐ Female

RACE: (select one or more) ☐ White ☐ Black or African American
☐ Asian Specify _____
☐ American Indian or Alaska Native
☐ Native Hawaiian or other Pacific Islander Specify _____

ETHNICITY: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

STATUS AT DIAGNOSIS
☐ Alive
☐ Dead
↓
Date: _____

ADDRESS:
Street _____ Apt. # _____
City _____ County _____ ZIP _____

COUNTRY OF ORIGIN:
☐ **U.S.** ☐ **Other → Which country?** _____ **→ Date entered U.S.** ☐☐ Month ☐☐ Day ☐☐☐☐ Year

Alien Number (A#) _____

Did client enter country as:
☐ Class A
☐ Class B1
☐ Class B2

Previous Diagnosis of Active TB Disease:
☐ **No** ☐ **Yes → Year of DX** _____
☐ **More than one episode**

Previous Therapy: _____

PREVIOUS TREATMENT FOR LATENT TB INFECTION?
☐ No
☐ Yes → Dates: ☐☐ Month ☐☐ Year to ☐☐ Month ☐☐ Year

DIAGNOSTIC INFORMATION

MAJOR SITE OF DISEASE:

_____

Additional Site: _____

SKIN TEST
Date Given: _____ By: _____
Date Read: _____ By: _____

RESULTS
☐ Negative
☐ Positive → Induration in mm: _____
☐ Unknown
☐ Not done

Fluid Specimens	Date(s) Collected	Smear Pos|Neg|Pend|Not done	Culture Pos|Neg|Pend|Not done
Sputum(s)	_____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	_____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
	_____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Bronchial Wash	_____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Gastric Aspirate	_____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Pleural Fluid	_____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Urine	_____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐
Other _____	_____	☐ ☐ ☐ ☐	☐ ☐ ☐ ☐

Date results received: _____

Biopsy Specimens for histopathology & Culture

	Date Collected	AFB Stain	Necrotising granuloma	Culture
Lymph node	_____	_____	_____	_____
Pleura	_____	_____	_____	_____
Bone	_____	_____	_____	_____
Other	_____	_____	_____	_____

Please indicate results of specimen: positive, negative, or incomplete.

X-RAY

View _____
Date Read _____
Date Taken _____
By _____

Interpretation
☐ Normal ☐ Not done ☐ Unknown
☐ Abnormal → ☐ Cavitary
☐ Non-cavitary → ☐ Consistent with TB
☐ Inconsistent with TB

Status
☐ Stable
☐ Worsening
☐ Improving
☐ Unknown

INITIAL DRUG REGIMEN

☐ Isoniazid ☐ Ethambutol ☐ Kanamycin ☐ P.A.S. ☐ Ciprofloxacin
☐ Rifampin ☐ Streptomycin ☐ Cycloserine ☐ Amikacin ☐ Ofloxacin
☐ Pyrazinamide ☐ Ethionamide ☐ Capreomycin ☐ Rifabutin ☐ Other _____
☐ Combination therapy

Date Rx Started: _____

FREQUENCY:
☐ Daily ☐ Supervised
☐ Twice Weekly ☐ Unsupervised
☐ Other

RISK FACTORS FOR TB

Mark those applying to clients within the past 12 months:

☐ Homeless ☐ Non-IV Drug Use
☐ IV drug use ☐ Excess Alcohol

Mark those applying to client at time of diagnosis:

☐ Resident of correctional facility
If yes: ☐ Federal Prison ☐ Local Jail ☐ Other Correctional Facility
☐ State Prison ☐ Juvenile Correction Facility ☐ Unknown

☐ Resident of long term care facility.
If yes: ☐ Nursing Home ☐ Mental Health Residential Facility ☐ Unknown
☐ Hospital-Based Facility ☐ Alcohol or Drug Treatment Facility
☐ Residential Facility ☐ Other Long Term Care Facility

Occupation: Mark all that apply within the last 24 months.
☐ Health care worker ☐ Migratory agricultural worker ☐ Not employed within last 24 mos. (Including housewife, retired, student, etc.)
☐ Correctional Emp. ☐ Other employment ☐ Unknown

HIV INFORMATION

HIV TESTING:
HIV Test Offered ☐ Yes ☐ No
HIV Test Given ☐ Yes ☐ No
HIV Status ☐ Pos. ☐ Neg.

Date Given _____ Date Offered _____
☐ Test Recommended
☐ Test Done, Results Unknown
☐ Refused Testing

HARS No._____

If positive, based on:
☐ Medical Document
☐ Client History
☐ Other _____

ADDITIONAL INFORMATION

PRIMARY TB CASE PROVIDER:

Facility Name _____

Clinician _____

DOT PROVIDER:

Facility Name _____

Clinician _____

INSURER:
☐ MSC
☐ Group Health
☐ Health Plus
☐ Kaiser
☐ Qual Med
☐ Other
_____

PAYER:
☐ Public
☐ Private
☐ Self

CASE CLOSURE REPORT

DATE MEDICATION/THERAPY STOPPED:

☐☐ ☐☐ ☐☐☐☐
Month Day Year

REASON FOR CLOSURE:
☐ Completed Therapy ☐ TB Related Death Date: _____
☐ Moved
☐ Lost to Follow-Up ☐ Non-TB related death Date: _____
☐ Not TB
☐ Uncooperative/Refused
☐ Other _____ (Drug Intolerance/Administrative Closure)

Sputum Culture Conversion ☐ Unk ☐ Yes ☐ No

Date Initial positive sputum _____

Date First negative sputum _____

TYPE OF HEALTH CARE PROVIDER: ☐ **Health Dept.** ☐ **Private/Other** ☐ **Both (HD/Other)**

DIRECTLY OBSERVED THERAPY (DOT)
☐ Yes, Totally DOT - Number of weeks _____
☐ Both, DOT and Self-Administered - Number of weeks DOT _____
☐ No, Totally Self Administered

SITE OF DOT:
☐ Clinic or other facility
☐ In the field
☐ Both, facility and field

COMMENTS